

## Social Support as a Resilience Factor for Parent-Infant Dyads Experiencing Homelessness

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### Abstract

Despite the considerable prevalence of homelessness among very young children in the U.S., there is a notable lack of research on risk, resilience, and developmental wellbeing of infants who experience family homelessness. In the present study, we considered social support as a resilience factor for quality of parent-infant relationships and parent depression among a sample of 106 parents and their infants (ages birth to 12 months) residing in emergency shelters for families experiencing homelessness. We assessed social support, parent histories of adverse experiences during childhood and adulthood, and parent current depression symptoms via structured interview measures, and we assessed quality of the parent-infant relationship with an observational approach. Results showed different patterns for the roles of adversity the parents had experienced during childhood compared to adversity experienced more recently, as adults. Childhood adversity predicted parent-infant responsiveness, with a positive association that was moderated by level of perceived social support. Parents with more childhood adversity showed more responsiveness with their infants only when they had access to high levels of social support. Adulthood adversity predicted higher scores for parent depression, while social support predicted lower parent depression scores. This work contributes to the very limited literature on the functioning of families with infants in shelters for families experiencing homelessness. Our discussion includes implications for research, policy, and prevention and intervention efforts.

**Keywords:** *family homelessness; resilience; parenting; responsiveness; social support; infants*

**Social Support as a Resilience Factor for Parent-Infant Dyads Experiencing Homelessness**

Infants account for a substantial and disproportionate number of children who stay in emergency homeless shelters in the United States, with the first year of life being the time most likely for individuals to enter homeless shelters (Shaw, 2019). Estimates from 2020, the most recent data available, suggest that about 416,907 people staying in emergency shelters at some point in the year were persons in families, and children under 6 years old made up an estimated 29.1% of all persons in families staying in shelters (Henry et al., 2022). Earlier reports estimating family homelessness in 2018 provided more detailed age-estimates, finding that about 12% of all 501,000 persons in families staying in shelters were under 2 years old that year (Henry et al., 2020; Shaw, 2019).

Despite the stunning prevalence of homelessness among very young children, there is a notable lack of research on risk, resilience, and developmental wellbeing of infants who experience family homelessness (Fanning, 2021; Haskett et al., 2016; Herbers et al., 2020; Shaw, 2019). Infants who experience family homelessness are at elevated risk for health problems, developmental delays, and social-emotional difficulties compared to non-homeless peers (Cutts et al., 2018; Fanning, 2021; Haskett et al., 2016). Considering the larger evidence base showing poor outcomes among older children experiencing family homeless (Bassuk et al., 2020; Haskett & Armstrong, 2019; Herbers, Cutuli, Keane, & Leonard, 2020), along with the fact that infancy is a particularly sensitive period of developmental neuroplasticity (Shonkoff & Garner, 2012), there is a clear need for more and better information about risk and resilience factors for infants experiencing homelessness. The current study aimed to consider social support and adverse experiences as predictors of family functioning—in terms of both caregiver depression symptoms and responsiveness in parent-infant relationships. We examined whether caregivers

with histories of more adverse experiences, both in childhood and in adulthood, would show more symptoms of depression and less responsiveness with their infants. We also tested whether social support available to families would moderate adversity-related risks to promote and protect resilient family functioning.

### **Adaptive Systems for Resilience in Families Experiencing Homelessness**

Ecological systems theory, attachment theory, and the family stress model of poverty all recognize that child wellbeing depends on a parent's functioning and access to supportive resources (Bronfenbrenner & Morris, 2006; Conger et al., 1992; Sroufe, 2016). Lack of financial, physical, and social resources in contexts of poverty both deprive children of opportunities and contribute to caregivers' psychological stress (Duncan et al., 2019). When a parent or other primary caregiver's functioning is compromised by mental health problems, particularly depression, their infant faces heightened risk for later emotional and behavioral problems (Mueller et al, 2019). The risk is conveyed through processes at the level of the parent-infant relationship, and is especially potent in contexts of poverty, when symptoms of depression including negative mood, irritability, low energy, and restricted affect limit the parent's ability to respond with warmth, sensitivity, and consistency to the infant's needs (Lovejoy et al., 2000).

With their primary caregivers, infants experience dyadic coregulation that serves not only to meet their most basic needs for survival, but also as a foundation for their developing capacity for self-regulation of behavior, cognition, and emotion (Herbers et al., 2020). When infants experience consistently sensitive and responsive caregiving, they are more likely to develop secure attachment relationships that support self-efficacy and a sense of trust in other people as sources of nurturance and positive engagement. This early foundation prepares infants to engage with their environments effectively, with curiosity and confidence as well as self-regulation

skills to manage challenges and cope with stressors (Sroufe, 2016). Secure attachment relationships are considered potent protective factors, predicting a host of resilient outcomes for children in contexts of poverty and other psychosocial adversity (Masten et al., 2021). As a specific example, secure attachment moderated risks for behavioral problems associated with maternal depression among young African American children from low-income families (Whittenburg et al., 2022).

To foster these secure attachment relationships, parents must establish patterns of nurturing, responsive, and reciprocal interactions with their infants (Sroufe, 2016). Meeting the needs of young children can be challenging in any context, and it is especially so for parents who experience poverty and housing instability. As a group, parents experiencing family homelessness have high rates of acute risks associated with loss of housing and residential mobility as well as numerous chronic risks associated with extreme poverty (Haskett & Armstrong, 2019). Acute risks can include adverse events that precipitate homelessness such as job loss, eviction, natural disaster, or domestic violence, and challenges associated with relocating such as loss of possessions, disconnections from social support and community services, and adjusting to emergency shelter or other temporary situations. Poverty-related chronic risks for caregivers experiencing family homelessness include low income, unemployment/underemployment, limited educational backgrounds, and elevated rates of physical and mental health problems (Bassuk et al., 2020). Most caregivers experiencing family homelessness are single mothers; disadvantaged and minoritized groups including Black and Hispanic/Latina women are overrepresented (Bassuk et al., 2020). Parents' own histories of adverse experiences also contribute to, and exacerbate, the proximal challenges of chronic poverty and acute stress.

**Histories of Childhood Adversity for Parents Experiencing Homelessness**

Adverse childhood experiences such as maltreatment, neglect, incarceration of parents, and parent mental health problems are disproportionately prominent in the histories of adults who experience homelessness (Cutuli, Montgomery et al., 2017; Duncan et al. 2019; Radcliff et al., 2019). From a developmental psychopathology perspective, exposure to maltreatment and family dysfunction in children's early experiences can impede healthy development in multiple ways: by fostering insecure attachments, modeling maladaptive behavior, and disrupting development of effective self-regulation (Cicchetti & Valentino, 2006; Lomanowska et al., 2017; Radcliff et al., 2019). For some individuals whose contexts are lacking in adequate resilience factors, the physiological strain, emotional trauma, and maladaptive coping skills can contribute to mental health problems like depression, anxiety, substance use problems, and posttraumatic stress (Portwood et al., 2021). Having more adverse experiences in childhood predicts a greater likelihood of having more adverse experiences in adulthood (Stern & Thayer, 2019). These adversities in childhood and adulthood then accumulate further and exacerbate poor functioning. When childhood and later adversities are considered together, there is evidence that formative experiences very early in life may be more impactful for adult outcomes than proximal stressors and additional adversities that occur in adulthood, though ongoing stress has meaningful impacts as well (Masten et al., 2021; Narayan et al., 2021; Narayan et al., 2013; Sroufe, 2016).

Early adversity can have intergenerational impacts when caregivers struggling with their own histories of childhood trauma and lacking in knowledge of parenting skills cannot provide the consistency and responsiveness needed to foster a positive parent-child relationship (Lomanowska et al., 2017; Narayan et al., 2021). Early experiences of abuse and neglect may be especially salient for parents of infants, as their own mental representations of attachment inform

their transition to the caregiving role (Narayan et al., 2021). In the context of poverty, which often persists across generations, adverse childhood experiences may compound other challenges that place caregivers at even greater risk for problematic parenting. Stressful episodes such as interpersonal losses are associated with less responsive and more negative parenting (Evans et al., 2008). Experiencing potentially traumatic events like childhood abuse or death of a family member increases the likelihood that a parent will engage in harsh or hostile parenting behaviors, especially when the parent has trouble coping and develops internalizing symptoms (Kiser & Black, 2005). Maternal posttraumatic stress symptoms and cumulative trauma are associated with higher levels of insensitive or hostile parenting, as well as lower responsiveness with their infants (Cohen et al., 2008). Previous research has found a relationship between maternal trauma and harsh parenting, with more trauma predicting more punishment and a higher potential for child abuse (Cohen, et al., 2008; Cross et al., 2018).

Compared to stably housed caregivers, parents experiencing homelessness report higher rates of adverse childhood experiences and higher rates of depression and posttraumatic stress symptoms (Bassuk et al., 2015; Chan et al., 2021). Ninety-three percent of mothers who experienced homelessness reported at least one traumatic event in their lifetime, with 73% describing multiple traumatic exposures, and 54% meeting diagnostic criteria for post-traumatic stress disorder (Schuster et al., 2011). In studies with preschool and school-aged children, families experiencing homelessness demonstrated more adverse parenting practices compared to families that were stably housed (Holtrop et al., 2017; Park et al., 2015).

Despite this multitude of challenges, many families who experience homelessness demonstrate resilience in terms of competent child functioning, caregiver functioning, and parent-child relationships (Haskett & Armstrong, 2019; Herbers et al., 2020). These different

aspects of resilience often co-occur, they can support each other over time, and they also arise through support from the same external resources and other resilience factors available to many families (Masten et al., 2021). For example, preschool-aged children whose relationships with their parents are characterized by high levels of positive co-regulation show strong executive functioning skills and later success in kindergarten and first grade (Herbers et al., 2014; Labella et al., 2019). Perceived availability and quality of social support also build resilience in contexts of poverty and associated disadvantage (McGoron et al., 2020).

### **Social Support as a Resilience Factor**

When parents are coping with past or recent adversity, social support can moderate the impacts of stress on psychological functioning and physical health (Hostinar & Gunnar, 2015; Norman et al., 2013). Social support is most often operationalized as the perceived availability of assistance from others when needs arise or perceived degree of connectedness with or isolation from social networks (Cohen, 2004). In the stress-buffering model, perceived social support moderates the stress response not only with minor stressors, but also with major stressors such as trauma (Cohen, 2004). In a sample of African American mothers and their preschool-aged children, social support moderated the association between mother's history of adverse childhood experiences and their own children's externalizing behavior problems (Hatch et al., 2020). In families experiencing homelessness, the availability of social support may help parents to cope more effectively with sequelae of their own childhood adversity.

In circumstances of minor or recent stress, perceived social support may provide protection at the level of cognitive appraisal of the current event. For example, a mother who has just arrived in emergency housing may be more likely to interpret her situation as a temporary set-back rather than an embarrassing failure if she knows that her family and friends care about

what she is going through and want to help. Social support has also been shown to moderate the effects of stress on parenting behavior, possibly by increasing maternal responsiveness (Hostinar & Gunnar, 2015), bolstering parenting self-efficacy, and/or reducing symptoms of depression (Lee et al., 2011; Treat et al., 2020).

Perceived social support may be especially important when families enter temporary housing. A move to shelter can be stressful because mothers have lost access to a stable home usually in the context of other stressors like struggling to pay rent or fleeing an abusive relationship. In addition to these stresses, families may also have to overcome a sudden change in the availability of social support. They may be physically separated from the social support they relied on prior to loss of housing, or they may wish to create distance between their families and other individuals who used to provide support. In a sample of mothers with children ages 4-6 years residing in an emergency shelter for families, mothers' satisfaction with social support was related to the quality of their observed parenting (Lucke et al., 2021). In another study of families with children experiencing homelessness, higher levels of instrumental and emotional social support predicted greater improvements in self-reported parenting consistency (Marra et al., 2009). Whether and how social support may protect parent functioning and parent-infant relationships in families experiencing homelessness remains unknown.

### **The Present Study**

In the present study, we considered social support as a resilience factor for wellbeing of the parent and quality of parent-infant relationships for families experiencing homelessness. We assessed social support, parent adverse experiences during childhood and adulthood, and parent current depression symptoms via structured interview measures. We assessed quality of the parent-infant relationship with an observational approach. We expected that parents with more

adverse experiences in childhood and adulthood would report more depression and demonstrate less responsiveness with their infants compared to parents with fewer adverse experiences. We also expected that social support would predict less parent depression and more parent-infant responsiveness. Finally, we expected that social support would act as a resilience factor such that the negative impacts of parents' childhood adversity on parent depression and parent-infant responsiveness would be attenuated in the presence of higher levels of perceived social support.

## **Method**

### **Participants and Procedure**

Participants were 106 parent-infant dyads residing in eight different emergency shelters for families in the Philadelphia area. Based on a power analysis, the sample size was sufficient for detecting an effect size of .20 with power of .84 in planned analyses. Eligible families had to be living in the shelters, fluent in English, and have an infant under 12 months old. Recruitment occurred in two waves, as part of a pilot study in 2015-2017 ( $n = 52$ , cohort 1) and as a new wave between September 2018 and February 2020 ( $n = 54$ , cohort 2). The procedures relevant to this report were the same in each wave. After the first assessment in each study, families were randomized to a parenting intervention and followed for eight months. The present analyses include only data from the initial timepoint, prior to the intervention.

Infants were 54.7% male and 95.5% Black/African American or multiracial including Black/African American. Infants ranged in age from two weeks to 12 months old ( $M = 5.47$  months,  $SD = 3.52$ ). Parents were the infants' primary caregivers, with over 95% being biological mothers and the remaining being biological fathers. Parents ranged from 18 to 52 years old ( $M = 28.4$  years,  $SD = 6.6$ ), and 88.5% reported being either Black/African American or multiracial including Black/African American. Most parents (62.9%) reported being

unemployed, and most were single parents (91.5%) with 48.1% reporting no structured or informal assistance with childcare. Thirty-three percent reported having less than a high-school education, and 27% reported that their first child had been born when they were under 18 years old. Over half of the families had two or more children staying with them (54.7%), and 35.8% of these families included more than one child under the age of 5 years. On average, families had been staying in the shelters for 19.9 weeks prior to their participation ( $SD = 16.9$  weeks). Most parents (69.5%) reported having other episodes of homelessness in their lives prior to the current stay in emergency shelter.

Parent-infant dyads were recruited and participated onsite in the shelters where they were residing. After providing informed consent, participating parents and infants met with researchers for approximately 90 minutes in a private space. If there were siblings in the family present during the assessment, they were monitored and entertained by research assistants in an adjacent space during the session. Assessments included a structured parent interview, administered as spoken questions to avoid concerns about literacy, including self-report measures of demographics, history of stressful experiences, current social support, and current parent depression symptoms. Dyads also completed a 15-minute free play interaction. Research assistants instructed parents to use a standardized bin of age-appropriate toys and a clean baby blanket on the floor to play together as they normally would. Researchers left the room for the 15-minute duration, and sessions were video-recorded and later coded by raters who were unaware of other study information. Parents received \$30 gift cards in appreciation of their time.

All study procedures were approved by Villanova University's internal review board. Information regarding additional measures utilized in the study is available from the lead author by request. Data and study materials are not being made widely available due to their sensitive

and/or proprietary nature, but they may be obtained in de-identified form from the lead author by request. We report how we determined our sample size, all data exclusions, all manipulations, and all measures in the study. The study design was not preregistered.

## Measures

**Parent-infant Responsiveness.** Raters assessed the quality of responsiveness in the parent-infant relationship based on observational data from the 15-minute free play sessions. Raters assigned scores for Mutual Responsiveness Orientation (MRO), defined as close, mutually binding, cooperative, and affectively positive interactions (Aksan et al., 2006). MRO has been used extensively, with strong psychometric validity (Lotzin et al., 2015). The single global score is assigned to summarize the entire interaction based on observed quality of coordinated routines between parent and infant, harmonious rather than conflictual or negative communication, mutual cooperation, and overall positive emotional ambiance. MRO scores range from 1-5 on overall degree of responsiveness across these domains. With training and guidance from the first author, a developmental clinical psychologist with extensive observational coding experience, teams of raters trained to reliability on practice videos of similar dyads (infants residing with their parents in shelters, ages 0-12 months) prior to coding cases. The training process involved watching several video examples together and discussing important developmental changes in behaviors indicative of dyadic responsiveness from the newborn period through 12 months of age. Because the scores were global and dyadic rather than defined by discrete behaviors, raters were able to account for comparable relationship quality despite the dramatic developmental change across this age range. Once trained, raters worked in pairs with reliability of independent coding acceptable at  $ICC = .71$ . Discrepancies were resolved by conference to arrive at a single score for each dyad.

**Parent Depression.** Parents responded to 14 items from the Symptom Checklist-25, reporting on symptoms of depression they had experienced within the past week (Derogatis et al., 1974). Sample items include “feeling blue” and “feeling as if everything is an effort.” Respondents rated their experience of each symptom on a 4-point Likert scale from 1 (not at all) to 4 (extremely). Scores for all items were averaged as a continuous measure of current depression symptoms. Item-responses showed high internal reliability in this sample,  $\alpha = .91$ .

**Parent Adversity.** Parents responded to the Lifetime Life Events Questionnaire (Gest et al., 1999), indicating whether any of a list of 20 stressful life events had occurred in their lifetime. This assessment of adversity has been used in other studies of families experiencing homelessness (Cutuli, Ahumada et al., 2017; Lafavor et al., 2020). Sample items included having been a victim of violence, witnessing violence, and death of a parent or other close family member. For each item endorsed, parents were then asked if this event occurred before they were 18 years of age, after 18 years of age, or both. A score of childhood adversity was calculated as the sum of unique negative life event categories endorsed as occurring prior to age 18, and a separate score of adulthood adversity was calculated as the sum of unique negative life event categories endorsed as occurring after age 18. An event endorsed as occurring both before and after was included in the sums of both scores for that individual. Frequencies of endorsements of the adverse life events in childhood and adulthood are listed in Table 1.

**Social Support.** Interviews assessed perceived social support with five items asking parents whether they believed that assistance with certain issues would be available if needed. These items used in the Pregnancy Assessment Monitoring System (PRAMS), a cross-sectional survey developed by the CDC to gather representative data on pregnancies in the United States (PRAMS, 2016; Shulman et al., 2018). Participants responded “yes” if they believed they would

have access to that type of support and “no” if they did not. Types of support were instrumental (“someone to loan me \$50,” “someone to help me if I were sick and needed to be in bed,” and “someone to take care of my baby”) and emotional (“someone to talk with about my problems” and “someone to help me if I were tired and feeling frustrated with my new baby”). Internal reliability for the five items was good,  $\alpha = .80$ . We summed the total number of items to which the parent responded affirmatively as a composite score ranging from 0 to 5. In previous work with families in shelters, the 5-item sum showed convergent validity compared to scores from the Ecomap, an established and more detailed measure (Tabachnick, 2016; Crawford et al., 2014).

### **Plan for Analysis**

Some data were missing for study measures due to incomplete interview sessions that had to be stopped early out of respect for family needs. Complete data were available for demographic measures and social support. Three parents were missing the measure of depression symptoms, and four were missing the adversity assessment. Some dyads ( $n = 17$ ) were missing observational parent-infant interaction data because infants were asleep or too distressed to complete an observational play session. Patterns of missingness were consistent with either Missing Completely at Random or Missing at Random, supported by a Little’s MCAR test of  $\chi^2(20) = 29.4, p = .187$ . As such, we used full information maximum likelihood estimation (FIML) to account for missing data in all study analyses.

To test our hypotheses, we conducted a path analysis in MPlus version 8 (Muthén & Muthén, 2017) with variables of social support, childhood adversity, adulthood adversity, and the interaction of childhood adversity and social support predicting responsiveness and parent depression. Both social support and childhood adversity were mean-centered, and we computed

the interaction term as the product of mean-centered childhood adversity and mean-centered social support. Child age in months, parent age in years, and study cohort were included as control variables predicting outcomes. Parent age was allowed to correlate with childhood adversity and adulthood adversity based on *a priori* expectations that older parents would have had more time to experience adulthood adversities and might be less likely to recall childhood adverse experiences than younger parents. We considered fit statistics based on a threshold for adequate fit of RMSEA < .08, TLI > .80, and CFI > .80 (Cangur & Ercan, 2015).

### Results

Table 2 presents descriptive statistics and bivariate correlations of study variables. The path analysis model had an adequate fit to the data,  $\chi^2(21) = 25.9, p = .209$ , RMSEA = .047, TLI = 0.94, and CFI = 0.92. Overall, the model predicted 38.3% of the variance in parent-infant responsiveness,  $p = .003$ , and 20.6% of the variance in parent depression,  $p = .006$ . Table 3 shows all coefficients for the path analysis model.

Within the path model (Figure 1), there was a significant, positive pathway from the interaction term of social support by childhood adversity predicting responsiveness,  $\beta = .24, p = .004$ . At higher levels of parent childhood adversity, there was a significant positive association for the simple slope of social support predicting responsiveness,  $b = .22, p < .001$ , whereas there was no significant effect of the simple slope for social support predicting responsiveness at lower levels of childhood adversity,  $b = .09, p = .311$  (Figure 2). The pathway from childhood adversity to responsiveness was also significant  $\beta = .20, p = .001$ . Pathways from social support and adulthood adversity to responsiveness were not significant. For parent depression, pathways were significant from social support,  $\beta = -.31, p = .004$ , and adulthood adversity,  $\beta = .33, p =$

.021. Effects were not significant for the interaction of childhood adversity and social support for parent depression.

Overall, hypotheses were partially supported. There were significant direct effects of childhood adversity on responsiveness and of social support and adulthood adversity on parent depression. There was a significant interaction effect of childhood adversity and social support predicting responsiveness, but not parent depression.

### **Discussion**

Findings from this study provide insight into risk and resilience factors impacting functioning among families with infants staying in homeless shelters. The significant moderation effect demonstrated that parent experiences of childhood adversity presented risk for parent-infant responsiveness only when perceived social support was low. Social support also predicted lower scores for parent depression as a main effect, indicating that social support may be an important resilience factor among these families. Our study helps to elucidate the distinct roles of childhood and adulthood adversity for different aspects of family functioning during experiences of family homelessness. Because family homelessness is a complex circumstance that can vary according to the characteristics of each family, understanding unique pathways between adverse experiences and resilient or maladaptive outcomes is important for supporting families living in shelters.

Contrary to our expectation that childhood adverse experiences would predict lower levels of responsiveness, we found a positive bivariate correlation between childhood adversity and parent-infant responsiveness. In the context of the significant interaction with social support, however, it is clear that this positive association only exists for caregivers with high childhood adversity and high levels of perceived social support. From a resilience perspective, this

indicates successful adaptation for some caregivers who, despite histories of adversity in childhood, can utilize resources like social support to function well. It is interesting to note that adulthood adversity was not significantly correlated with responsiveness, either positively or negatively. Instead, adulthood adversity significantly predicted parent symptoms of depression, while childhood adversity experienced by the parent was not significantly associated with parent depression. These differences support theories that adversity has differential impacts depending upon developmental timing. In other words, childhood experiences of adversity and adulthood experiences of adversity contribute to distinct developmental processes, with unique impacts on an individual and their broader family system.

The significant interaction effect between social support and parent childhood adversity for predicting responsiveness is consistent with a stress buffering model of social support, at least when it comes to parent-infant responsiveness (Cohen, 2004). For parents who had experienced fewer than three adverse lifetime events during their childhood, similar levels of responsiveness were observed among those parents reporting both high and low levels of perceived social support (see Figure 2). However, for parents who had experienced three or more adverse events in childhood, those parents reporting higher levels of social support showed significantly more responsiveness with their infants than those parents who had reported low levels of social support. As suggested by the stress buffering model, social support was important for mitigating the impacts of stressful experiences and childhood adversity on parent-infant relationships, but social support did not predict differences in parent-infant relationship quality among parents with histories of fewer adverse experiences. Social support also directly predicted differences in caregivers' depression symptoms, consistent with the literature linking parent depression and social support (Lee et al., 2011; Treat et al., 2020).

Contrary to our expectations, there was no significant correlation between parent depression symptoms and responsiveness. Previous research has suggested that parent depression and associated emotional difficulties increase the risk for negative parenting behaviors, especially in contexts of poverty and homelessness (Haskett & Armstrong, 2019). It is likely that the cross-sectional nature of this study did not give a full picture of parent mental health problems including clinical depression or other mental illness, that would shape positive and negative parenting behaviors. Our measure did not distinguish between those parents who might be feeling depressed as an acute, time-limited response to current stressors and those parents with more persistent and chronic symptoms. Previous research with families in shelters suggests that, on average, parent distress may decrease over the period of stay in emergency housing (Herbers et al., 2020). Depression symptoms that represent a more time-limited reaction to acute stressors would not necessarily be linked with current patterns of parent-infant responsiveness though persisting symptoms may contribute to problematic patterns over time.

Findings also suggest practice and policy implications, though tenuous until additional research replicates and deepens understanding of these associations. Social support promotes resilience for young families experiencing homelessness demonstrated in this study with the findings that social support protects responsiveness in the face of parents' childhood adversity while also predicting lower levels of depression symptoms for parents. When a family enters an emergency shelter, they may be required to relocate to a new neighborhood and must adapt to regulations required for participation in a housing program (Haskett & Armstrong, 2019). These circumstances are likely to impact access to social support for families, and it would be valuable for policies and programs that aim to assist these families to consider ways to maintain links with previous sources of social support and to facilitate the establishment of new supports particularly

for families lacking such connections. Homelessness response plans and centralized intake procedures could incorporate efforts to help families receive shelter or alternative emergency housing interventions where families come from or where important social support exists. These supports could be informal, such as friends and family, or formal systems supports, such as geographies with available early childhood programs or particular shelters with such programs on site. In addition, shelter policies that prohibit visitors may be well-intentioned or vital in some cases (e.g., to preserve families' privacy or limit access from domestic violence perpetrators) but also make it difficult for families to maintain connections to loved ones. Shelters may want to consider holding organized events that friends or family could attend or offering transportation (e.g., public transportation fares) for families in shelter to visit with loved ones. Optional programming to encourage support among families in shelters and to connect families with community resources in comfortable settings (e.g., early care and education programs; Cutuli & Willard, 2019) could also encourage caregivers to build new support networks through their time of housing transition. Approaches to service provision that are trauma-informed also have potential to alleviate challenges for families coping with limited social support and substantial histories of adverse experiences (Bassuk et al., 2020). Finally, emergency and transitional housing programs are inherently child- and family-serving interventions, given the large number of families that they serve. By the same rationale, they are also early childhood agencies, given the large percentage of infants, toddlers, and young children that they serve. Consistent with earlier calls in the literature (e.g., Cutuli & Herbers, 2014), it is important that these programs be informed by a developmental perspective and that their efficacy be judged on how well they support important needs and outcomes of the children and families that they serve. In this way,

the results of the current study underscore the importance of preserving and promoting social support for parents with infants in these housing programs.

### **Strengths and Limitations**

Our study contributes to the sparse literature on families with infants experiencing homelessness. Early childhood is a foundational period of development when children are highly dependent on their caregivers, and infants under 12 months make up a substantial portion of the population of children experiencing family homelessness. As such, this group of parents and children deserve more attention from researchers, service providers, and policymakers to better understand and serve them in the face of housing instability and homelessness. Our sample of caregivers residing in emergency shelters with infants under 12 months of age is rare, and our approach to measurement including parent self-report measures and more objective, observational coding of parent-infant interaction lends strong support for our findings.

In this study, we followed a risk and resilience perspective to evaluate the roles of caregivers' adverse experiences during both childhood and adulthood for family wellbeing. The results affirm expectations based on the literature and the developmental psychopathology perspective that adverse experiences in childhood and adulthood can impact families in unique ways (Narayan et al., 2021; Sroufe, 2016). Separating adverse experiences based on developmental timing provides insight into the complex ways that adversity interacts with other risk and resilience factors in pathways of development. Both adverse childhood experiences and adverse experiences during adulthood are important for understanding different aspects of individual and family functioning.

Limitations of this study include relying on parent self-report for several measures, which could introduce shared method variance for those constructs. For parent-infant responsiveness,

our use of an observational measure was preferable to parent self-report. Still, one-time observations can be biased by context or other situational noise. Another important measurement limitation was the use of a brief, five-item measure combining different aspects of social support, emotional and instrumental, into a single scale. The measure was selected for its brevity and efficiency, and we have evidence from our previous work of its association with an established measure of social support in this population. However, use of this measure did not allow us to consider unique impacts of different aspects of social support. More comprehensive measures of social support, parent-infant responsiveness, and family wellbeing could be included in future studies with families experiencing homelessness to address whether certain types of support are more pertinent for family wellbeing in the shelter context.

Although this study provided valuable information about some of the associations among adverse experiences, social support, and parent functioning, future studies using longitudinal data would enhance our knowledge of ways that family functioning can change, whether their stay in shelter is short or long. Due to the cross-sectional nature of this study, it is not clear if the depression symptoms reported by caregivers reflected acute stressors related to loss of housing or more persistent patterns of depression and mental illness. Further, it would be interesting to learn about the social support or other resilience factors, including those sometimes called “benevolent childhood experiences,” that may have been available to caregivers during their adverse experiences in childhood (Merrick et al., 2019). Supportive caregiving during adversity in childhood is vital for promoting resilience at the time of the stressor and can even render stressful experiences manageable, preparing individuals to cope successfully in the face of future adversity (Shonkoff et al., 2012). Finally, studies with longitudinal outcomes regarding later child functioning in key development domains like cognition and emotion would provide a more

complete picture of the roles of adversity, social support, caregiver functioning, and parent-infant relationships for healthy development in the context of family homelessness.

## **Conclusion**

While future research can further elucidate the associations between caregiver experiences of adversity, social support, and family functioning, this study provides support for the role of social support as a resilience factor for families experiencing homelessness with their young children. The importance of social support for family functioning during episodes of homelessness indicates that families should have access to policies and programs that encourage them to draw on previously established support systems and to build new supportive connections. Overall, this work contributes to the literature about family functioning in contexts of homelessness by investigating social support as a resilience factor for caregivers with infants who stay in family shelters. Young families facing homelessness are more likely to experience a host of associated poverty-related risks and adversities in addition to the acute risks of homelessness, making it especially important to understand how histories of adversity and current resources like social support interact to either compromise their functioning or promote resilience.

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**Table 1**

Frequencies (%) of adverse experiences during childhood (before 18) and adulthood (after 18).

| Adverse Experience                                 | Before Age 18 | After Age 18 |
|----------------------------------------------------|---------------|--------------|
| Death of a parent                                  | 18.9          | 17.9         |
| Death of another close family member               | 42.5          | 57.5         |
| Divorce/separation of your parents                 | 33.0          | 2.8          |
| Lost contact with parent                           | 27.4          | 19.8         |
| Victim of violence                                 | 24.8          | 17.1         |
| Lived in a foster home                             | 23.8          | 1.9          |
| Homeless/lived in a shelter (other than currently) | 13.3          | 61.9         |
| Hospitalized for mental health problem             | 15.2          | 9.5          |
| Incarcerated                                       | 14.3          | 14.3         |
| Parent hospitalized for physical illness           | 14.2          | 24.5         |
| Parent hospitalized for drugs/alcohol              | 12.3          | 6.6          |
| Hospitalized for physical illness                  | 9.5           | 21.9         |
| Death of a brother or sister                       | 9.4           | 12.3         |
| Parent hospitalized for mental health problem      | 7.5           | 5.7          |
| Death of spouse                                    | 3.8           | 12.3         |
| Death of child                                     | 3.8           | 9.4          |
| Convicted of a crime                               | 3.8           | 11.4         |
| Divorced or separated from a partner               | 2.8           | 28.4         |
| Hospitalized for drugs/alcohol                     | 1.9           | 7.6          |
| Developed handicap/disability                      | 1.0           | 10.5         |

**Table 2**

Descriptive statistics and bivariate correlations of study variables

|                          | <i>M</i> (SD) or<br>percentage | 2    | 3    | 4     | 5      | 6     | 7    | 8      | 9     | 10   |
|--------------------------|--------------------------------|------|------|-------|--------|-------|------|--------|-------|------|
| 1 Responsiveness         | 3.17 (1.00)                    | -.09 | .25* | .04   | .11    | -.18  | .07  | .04    | -.13  | .27* |
| 2 Parent depression      | 1.79 (0.61)                    |      | -.01 | .38** | -.35** | .15   | .04  | .18    | -.09  | .12  |
| 3 Childhood adversity    | 2.88 (2.07)                    |      |      | -.02  | -.10   | -.23* | -.01 | -.29** | -.09  | .08  |
| 4 Adulthood adversity    | 2.93 (2.30)                    |      |      |       | -.14   | .19*  | .02  | .49**  | -.05  | .17  |
| 5 Social support         | 3.85 (1.52)                    |      |      |       |        | -.15  | -.02 | -.05   | .12   | .05  |
| 6 Child age (months)     | 5.47 (3.52)                    |      |      |       |        |       | -.15 | .10    | .06   | -.12 |
| 7 Child gender (female)  | 45.3%                          |      |      |       |        |       |      | .04    | .02   | -.13 |
| 8 Parent age (years)     | 28.4 (6.64)                    |      |      |       |        |       |      |        | -.24* | .15  |
| 9 Parent gender (female) | 96.2%                          |      |      |       |        |       |      |        | -     | .19* |
| 10 Cohort (2)            | 50.9%                          |      |      |       |        |       |      |        |       | -    |

\* $p < .05$ ; \*\* $p < .01$

**Table 3**

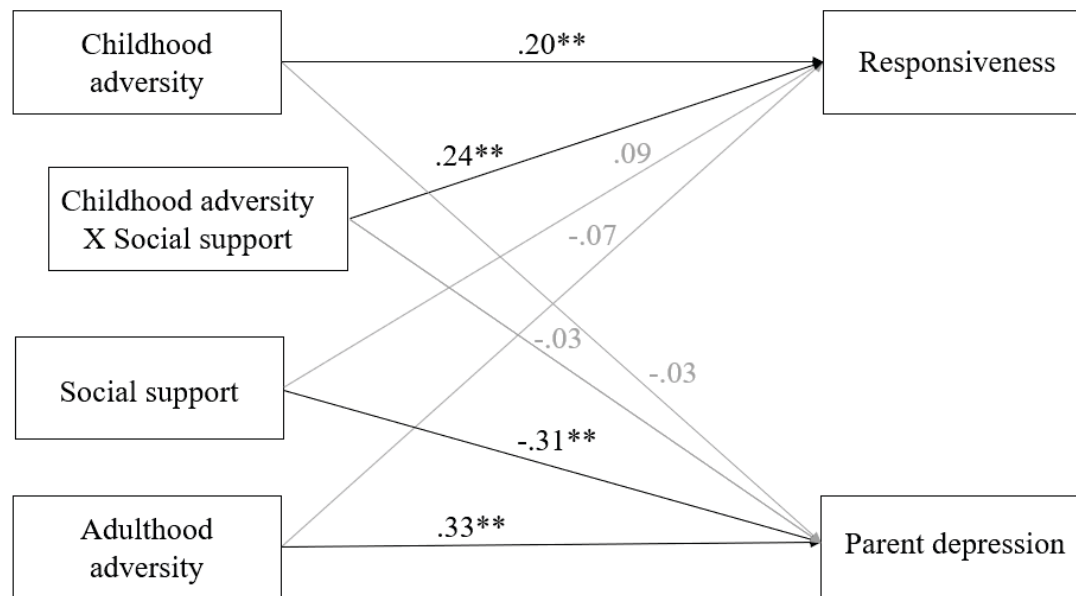
Coefficients for all effects tested in the path analysis model

|                                            | Responsiveness                |          | Parent depression             |          |
|--------------------------------------------|-------------------------------|----------|-------------------------------|----------|
|                                            | <i>B (SE)</i>                 | <i>β</i> | <i>B (SE)</i>                 | <i>β</i> |
| Child age                                  | -0.04 (0.03)                  | -.14     | 0.01 (0.02)                   | .04      |
| Parent age                                 | 0.01 (0.02)                   | .10      | 0.00 (0.01)                   | -.01     |
| Cohort (2)                                 | 0.99 (0.18)                   | .51**    |                               |          |
| Social support                             | 0.06 (0.06)                   | .09      | -0.13 (0.04)                  | -.31**   |
| Childhood adversity                        | 0.10 (0.04)                   | .20**    | -0.01 (0.03)                  | -.03     |
| Adulthood adversity                        | -0.03 (0.04)                  | -.07     | 0.09 (0.03)                   | .33**    |
| Interaction term:                          | 0.07 (0.02)                   | .24**    | -0.01 (0.02)                  | -.03     |
| Social support x Childhood adversity       |                               |          |                               |          |
|                                            | <i>R</i> <sup>2</sup> = .38** |          | <i>R</i> <sup>2</sup> = .21** |          |
| <b>Estimates (SE) for Parent age with:</b> |                               |          |                               |          |
| Childhood adversity                        | -3.80 (1.26)**                |          |                               |          |
| Adulthood adversity                        | 7.26 (1.77)**                 |          |                               |          |

\* $p < .05$ ; \*\* $p < .01$

**Figure 1**

Results of path analysis showing standardized effects of childhood adversity, adulthood adversity, social support, and the interaction term to responsiveness and parent distress. Child age, parent age, and cohort were included as control variables but are not depicted here. Predictors of childhood adversity and adulthood adversity were allowed to correlate with parent age.



$X^2(21) = 25.9, p = .209, RMSEA = .047, CFI = 0.92, TLI = 0.94,$

\*\*  $p < .01$

**Figure 2**

Significant interaction effect for social support by parent's childhood adversity predicting responsiveness

